PU 03-02

## Physical, Occupational and Massage Therapy

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## **Purpose**

The purpose of this Update is to clarify the department's rules and policies for outpatient physical, occupational, and massage therapy providers. It is designed to be a quick reference to pertinent Washington State Workers' Compensation coverage and payment policies, rules and expectations.

No change in policy is being made. Please make and provide copies of this document to all therapy and billing staff.

This Update supports the existing Washington Administrative Code (WAC), fee schedule and payment policies. The WAC, fee schedule and payment policies will always supersede information contained in this Update.

The information in this Update applies to State Fund (industrial insurance coverage through Labor and Industries) and self-insured employers unless otherwise specified.

#### **Contacts**

Provider Hotline 1-800-848-0811 902-5600 in Olympia Karen Jost, MS, PT Therapist Consultant Coordinator PO Box 44323 Olympia WA 98504-4323 (360) 902-5622 (360) 902-5035 fax

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#### **Authorized Providers**

# What type of therapy providers may perform physical therapy (PT)/occupational therapy (OT)/massage therapy (MT) services?

Licensed physical therapists or physical therapist assistants serving under the direction of a licensed physical therapist may provide physical therapy services.

(WAC 296-23-220 Physical therapy rules; WAC 296-21-290 Physical medicine)

Licensed occupational therapists or licensed occupational therapist assistants serving under the direction of a licensed occupational therapist may provide occupational therapy services.

(WAC 296-23-230 Occupational therapy rules).

Licensed massage practitioners may provide massage therapy services.

(WAC 296-23-250 Massage therapy rules)

#### Are providers paid for services performed by other personnel?

No. The department will not pay providers for services provided by exercise physiologists, kinesiologists, athletic trainers, aides and other unlicensed personnel.

(WAC 296-20-015 (1-2) Who may treat; WAC 296-23-220 Physical therapy rules; WAC 296-23-230 Occupational therapy rules)

## How can providers become approved to provide and be paid for work hardening services?

Contact the work hardening reviewer at (360) 902-5622. Providers will be asked to submit documentation demonstrating that their program satisfies the requirements listed in the work hardening program standards. A copy of the standards is available on request from the reviewer, and can be obtained online at <a href="http://www.LNI.wa.gov/ClaimsInsurance/Providers/ReturnToWork/WorkHard/">http://www.LNI.wa.gov/ClaimsInsurance/Providers/ReturnToWork/WorkHard/</a>

# **Documentation Requirements**

#### What records do you need to send to the department or self-insurer?

Physical, occupational and massage therapy providers are required to submit chart notes and reports.

(WAC 296-20-06101 Reporting requirements)

#### When are progress reports required?

Physical and occupational therapy providers must submit progress reports after **12** treatment visits or one month (whichever occurs first). Send copies to:

- The attending doctor, and
- The department or self-insurer

(WAC 296-23-220 Physical therapy rules; 296-23-230 Occupational therapy rules)

Massage therapists must submit progress reports after **6** treatment visits or one month (whichever occurs first). Send copies to:

- The attending doctor, and
- The department or self-insurer.

(WAC 296-23-250 Massage therapy rules)

## How does the department prefer to receive medical records (claim correspondence)?

The department prefers to receive claim correspondence by mail, unless a Labor and Industries staff member specifically requests a fax. Routinely submitting claim information by fax to the claim unit fax line does not mean the claim manager will review it more quickly.

Note: Medical records and bills for State Fund claims are to be sent to separate addresses. See the correspondence address below, and refer to appendix A for the appropriate billing addresses.

Mail claim correspondence (chart notes, reports, and letters – NOT bills) for State Fund claims to:

Department of Labor and Industries PO Box 44291 Olympia, WA 98504-4291



- Put the patient's name and claim number in upper right hand corner
- Use plain, white, 8½" x 11" paper, one side only, no partial sheets of paper
- Avoid the following:
  - Colored paper
  - o Carbonless paper
  - o Highlighter markings
  - Shaded areas
  - o Dark or black borders or logos, especially on the top border

For self-insured claims, send the bills and correspondence to the self-insured employer or their representative.

(Payment policies: Introduction – Submitting claim documents to the State Fund)

#### What kind of information should be included in daily notes?

Providers should chart using the SOAP (Subjective, Objective, Assessment, Plan) format. Records must verify the level, type and extent of services provided to injured workers.

Chart notes must be legible.

(WAC 296-20-010{7} General information; WAC 296-20-01002 Definitions, Chart notes; Payment policies: Introduction – Documentation requirements, and Charting format)

#### Does the department or self-insurer have a standard format for progress reports?

No. There is not a standard format for progress reports. However, progress reports must include:

- An outline of the proposed treatment plan, and
- Objective, measurable goals, including objective documentation of progress since the last report, and
- Expected length of treatment

(WAC 296-23-220 Physical therapy rules; WAC 296-23-230 Occupational therapy rules; WAC 296-23-250 Massage therapy rules)

The inclusion of simple visual aids such as charts or graphs (with appropriate explanations) along with your narrative report can present objective information in a manner that will allow a claim manager to

quickly determine whether therapy services are bringing about on-going improvement in function. For example:

Measure	Baseline (3/14/03)	4/11/03 Status	Current Status (5/9/03)	Goal	Notes (5/9/03)
R shld flexion AROM	140 degrees	155 degrees	155 degrees	170 degrees to enable overhead reach	Marked pain at end range
R shld abduction AROM	130 degrees	140 degrees	140 degrees	160 degrees	Marked pain at end range
Floor to waist lift	Not measured	15# occasional	25# occasional	35# occasional to meet job requirements	
Waist to shoulder lift	Not measured	10# occasional	10# occasional	35# occasional to meet job requirements	Limited by pain; note accessory muscle use
R upper trap hypertonicity	High	Moderate	Moderate	Mild to no hypertonicity	

This example shows that the worker initially responded well to treatment, but has a limitation with overhead activity. The table, along with the rest of your narrative report provides the claim manager with the information needed to decide if additional treatment should be authorized.

Progress reports must be legible.

(WAC 296-20-01002 Definitions, Chart notes; Payment policies: Introduction – Documentation requirements)

## Who is required to sign chart notes and progress reports?

The name, title and signature of the person performing the services must be included in all records submitted.

(WAC 296-20-01002 Definitions, Chart notes)

# **Billing/Payment**

## How does the department or self-insurer pay for outpatient PT/OT/MT services?

The Resource Based Relative Value Scale (RBRVS) is used as the basis of payment for most professional services. Refer to the fee schedules for payment amounts for specific billing codes. The fee schedule is available on the Labor and Industries web site at

http://www.LNI.wa.gov/ClaimsInsurance/ProviderPay/FeeSchedules/.

The fee schedule may be reviewed and/or adjusted by the department on an annual basis.

(WAC 296-20-132 Determination of conversion factor adjustments; Payment policies: Professional services – Washington RBRVS payment system and policies)

The department will pay for a maximum of one each PT, OT and/or MT visit per day. The maximum payment for all services by any provider type, on one day, is generally referred to as the daily maximum, and is established in the following:

- WAC 296-23-220 Physical therapy rules
- WAC 296-23-230 Occupational therapy rules
- WAC 296-23-250 Massage therapy rules

The daily maximum does not limit payment for the following services:

- Performance-based physical capacities evaluations
- Work hardening programs
- Pain management programs
- Job, home and/or vehicle modification consultations

#### How is the daily maximum applied?

The daily maximum applies to CPT<sup>®</sup> codes 64550 and 97001-97799 when performed for the same patient for the same date of service. If two types of therapist provide services on the same day, the daily maximum applies once for each provider type per claim.

For example, a worker receives massage therapy from a licensed massage practitioner and also receives appropriate complementary treatment from a physical therapy provider on the same day. Both the physical therapy provider and the licensed massage practitioner are eligible for payment up to the daily maximum.

(Payment policies: Professional Services – Physical Medicine)

#### How do I bill for modalities and untimed services?

For supervised modalities and therapeutic procedures that do not list a specific time increment in their description, bill one unit.

(Payment policies: Professional services – Physical medicine)

## What codes can a PT and/or OT provider bill for evaluation and treatment services?

The table below lists the most commonly used codes for PT and OT providers. Refer to the Physical Medicine and Biofeedback sections of the Professional Services Payment Policies for detailed information about these codes.

Providers may contact the Provider Hotline at 1-800-848-0811 to verify if other codes are payable.

Service provided	Billing code	Application/Limitation
Physical medicine per	97001-97799	Refer to the next question regarding
CPT <sup>®</sup> codes		codes that are not covered.
TENS fitting	64550	The department allows the initial TENS application and training by a physical therapist or other qualified provider
		only once per claim.
Job modification/Pre-job		Job modification and pre-job
accommodation services		accommodation consultations require
<ul> <li>Consultation</li> </ul>	0389R	prior authorization from the claim
<ul> <li>Travel/wait</li> </ul>	0391R	manager.
<ul> <li>Mileage</li> </ul>	0392R	
Ferry charges	0393R	
Work evaluation services		Work evaluation services are paid only
<ul> <li>Consultation</li> </ul>	0390R	when provided as part of a vocational
<ul> <li>Travel/wait</li> </ul>	0391R	evaluation and must be authorized in
<ul> <li>Mileage</li> </ul>	0392R	advance by the claim manager.
• Ferry charges	0393R	
Stand Alone or Provisional	0378R	Stand Alone or Provisional job analysis
job analysis		services are paid only when provided to
		assist a vocational counselor in the
		completion of a job analysis for a
		vocational referral. Requires prior
		authorization from the claim manager.
Performance-based physical	1045M	Payable only to physicians who are
capacities evaluation		board qualified or certified in physical
		medicine and rehabilitation, and to
		physical and occupational therapists.
		Does not require prior authorization.
Work hardening	1000M-1018M	Payable only to approved work
		hardening providers when authorized in
		advance by the claim manager

(Payment policies: Professional services – Physical medicine; Provider Bulletin 01-03 Vocational Rehabilitation Payment Guidelines, pages 9-10; Provider Bulletin 03-08 Vocational Rehabilitation Rule Changes)

## What physical medicine codes are not covered?

The following physical medicine codes are not covered:

CPT <sup>®</sup> 97005	Athletic training evaluation
CPT® 97006	Athletic training reevaluation
CPT <sup>®</sup> 97033	Iontophoresis, each 15 minutes
CPT® 97545*	Work hardening/conditioning
CPT® 97546*	Each additional hour
CPT® 97781	Acupuncture
HCPCS Q0086	PT evaluation/treatment, per visit

<sup>\*</sup> Work hardening services are paid with local codes only to approved providers

Refer to the appendices in the fee schedule for complete lists of non-covered codes.

## What codes will a licensed massage therapist be paid for?

Massage therapists will be paid for CPT<sup>®</sup> code 97124 for all forms of massage therapy regardless of the technique used. The department will not pay massage therapists for additional codes.

(Payment policies: Professional services – Massage therapy)

#### Does the department or self-insurer pay PT/OT/MT providers for phone conferences?

No. PT, OT and MT providers are not paid for phone conferences.

#### Can a PT and/or OT provider be paid for the review of job analyses?

No. The review of job analyses is payable only to attending doctors.

(Provider Bulletin 99-02 Payment for Job Analysis Review)

#### Can I get paid for all supplies/materials?

No. The department can only pay for services and supplies that are medically necessary and prescribed by an approved provider for the direct treatment of a covered condition.

Supplies used during the course of treatment are considered bundled and are not payable separately.

Refer to the department's Payment Policies – Supplies, Materials and Bundled Services, for additional information about billing and payment.

#### How should PT/OT providers bill for work conditioning?

Work conditioning services should be billed using the appropriate PT and OT billing codes (97001-97799). Note: CPT<sup>®</sup> codes for work hardening/conditioning (97545-46) are not covered.

(Provider Update 00-01, pages 10-12 "Work Conditioning and Work Hardening Services at the Department of Labor and Industries (L&I) in Washington State")

#### Can I bill for services performed by another licensed therapist?

No. A therapist can bill for services provided by an assistant, but not for services provided by another therapist. Each therapist must establish a provider account number with the department.

Provider account applications may be obtained by calling the Provider Hotline at 1-800-848-0811, or online at <a href="http://www.LNI.wa.gov/forms/pdf/248011a0.pdf">http://www.LNI.wa.gov/forms/pdf/248011a0.pdf</a>.

#### How should PT and OT providers bill for services not provided as one-on-one?

Group therapy services are defined (by CPT<sup>®</sup>) as services provided simultaneously by a therapist (as opposed to the therapist giving full attention to a single patient). The therapist must be in constant attendance during group therapy. CPT<sup>®</sup> code 97150 should be billed for each patient participating in group therapy.

Time spent by patients who are independently exercising (no therapist or assistant in constant attendance) is not billable.

#### **Authorization for Services**

#### How can I verify claim status information for State Fund claims?

For most claim and billing questions, your first contact should be the automated Interactive Voice Response (IVR) Message System at 1-800-831-5227. Use your provider account number and a touch-tone telephone to access information on the status of State Fund claims, allowed/denied diagnosis and procedure codes, current bill status and the name and phone number of the claim manager. The IVR line is available weekdays between 6 a.m. and 7 p.m.

#### Do I need to obtain authorization for the first twelve (PT/OT) or six (MT) visits?

No. Providers do not need to obtain authorization for the first set of treatment visits according to the physical, occupational and massage therapy rules.

(WAC 296-23-220 Physical therapy rules; WAC 296-23-230 Occupational therapy rules; WAC 296-23-250 Massage therapy rules)

# What criteria must be met in order to authorize treatment beyond the initial twelve (PT/OT) or six (MT) visits for an accepted industrial condition?

Authorization for additional services is dependent on documentation of the attending doctor's prescription for additional treatment, as well as objective documentation that the worker's condition is improving.

When this documentation is not available, claim managers may deny further treatment.

Providers are not required to contact the department in order to obtain authorization for services beyond the first set of visits.

However, many providers prefer to obtain this authorization. The procedure in the following three statements applies only to State Fund claims. For self-insured claims, contact the claim manager for the self-insured employer.

#### **Procedures for PT authorization beyond the initial twelve visits (State Fund only):**

- Outpatient PT authorization requests The department has implemented a fax authorization process for outpatient PT authorization requests. Fax forms are available on the web at <a href="http://www.LNI.wa.gov/forms/pdf/248055af.pdf">http://www.LNI.wa.gov/forms/pdf/248055af.pdf</a>, or by calling (360) 902-5309. Instructions are included with the form.
- To request authorization for other PT services (e.g., work hardening, work conditioning, supplies, etc.), call the Provider Hotline at 1-800-848-0811 to make a referral to the claim manager, or contact the claim manager directly.

## **Procedures for OT authorization beyond the first twelve visits (State Fund only):**

Only the claim manager may authorize requests for additional OT services. OT providers may call the Provider Hotline at 1-800-848-0811 to make a referral to the claim manager, or contact the claim manager directly.

## Procedures for MT authorization beyond the first six visits (State Fund only):

MT providers may call the Provider Hotline at 1-800-848-0811 to obtain authorization for the second set of six massage treatments.

For authorization beyond the second set, MT providers may call the Provider Hotline at 1-800-848-0811 to make a referral to the claim manager, or contact the claim manager directly.

#### **Treatment Issues**

## What should a PT/OT/MT provider do if the injured worker is not progressing in treatment?

Providers are expected to document their assessment of the injured worker's progress (or lack thereof) in chart notes and progress reports. If the care being provided is neither curative nor rehabilitative, providers should plan for discharge and clearly indicate progress is not being made.

Providing palliative care may prolong the claim and contribute to the possibility of long-term disability for the injured worker. Research shows that it is in the best interest of the injured worker to stop medical treatment once functional improvement has ceased.

If providers continue to receive referrals for therapy despite a recommendation to discharge the patient, please contact the claim manager for assistance.

(WAC 296-20-01002 Definitions, Proper and necessary)

#### What should a PT/OT/MT provider do if the injured worker is not participating in treatment?

Providers are expected to document cancellations and missed appointments. In addition, if the worker is not participating as expected, contact the claim manager directly for assistance.

# **Authority to Review Health Services Providers**

#### Why does the department review provider records?

The department reviews providers' patient and billing related records to make sure workers are receiving proper and necessary medical care and to make sure that providers comply with the department's Medical Aid Rules, fee schedules, and policies.

#### Can the department request records from a provider?

Yes. The department has the authority to request copies of provider's patient and billing related records. When the department requests records, they must be received by the department within 30 days of receipt of the request and should be legible.

(WAC 296-20-02010 Review of health services providers)

#### Can the department discipline a provider?

Yes. The department can take corrective action against providers. If a provider fails to comply with any order, rule, or policy, the department can ask for a refund of payments, assess penalties, or take other disciplinary action.

(WAC 296-20-015 Who may treat)

#### Resources

## How can a provider receive copies of the department's provider bulletins and updates?

If you would like a copy of any provider bulletins or updates mailed to you, or if you would like to be added to our Provider Bulletin and Provider Update mailing list, please write/phone/fax:

Washington State Department of Labor and Industries Health Services Analysis Section PO Box 44322 Olympia WA 98504-4322

Voice: 360-902-6799 Fax: 360-902-4249

Copies of individual provider bulletins and/or updates may be mailed on request from the Provider Hotline at 1-800-848-0811.

Provider Bulletins and Provider Updates are also available on the department's web site at <a href="http://www.LNI.wa.gov/ClaimsInsurance/Providers/ProviderBulletins/">http://www.LNI.wa.gov/ClaimsInsurance/Providers/ProviderBulletins/</a>.

# Appendix A

# Billing Addresses for Physical, Occupational and Massage Therapy Providers

Item	State Fund Mailing Address
UB-92 Forms	Department of Labor & Industries PO BOX 44266 Olympia, WA 98504-4266
Adjustments and Bills for Retraining & Job Modification, Home Nursing and Miscellaneous	Department of Labor & Industries PO BOX 44267 Olympia, WA 98504-4267
HCFA 1500 Form	Department of Labor & Industries PO BOX 44269 Olympia, WA 98504-4269
State Fund Refunds (attach copy of remittance advice)	Department of Labor & Industries Cashier's Office PO BOX 44835 Olympia, WA 98504-4835

## **Appendix B**

## **Department of Labor and Industries Web References**

- ♦ Home page: <a href="http://www.LNI.wa.gov">http://www.LNI.wa.gov</a>
- ❖ Claims and Insurance information: <a href="http://www.LNI.wa.gov/ClaimsInsurance/">http://www.LNI.wa.gov/ClaimsInsurance/</a>
- ❖ Provider information: <a href="http://www.LNI.wa.gov/ClaimsInsurance/Providers/">http://www.LNI.wa.gov/ClaimsInsurance/Providers/</a>
- Provider Bulletins (PB) and Updates (PU): http://www.LNI.wa.gov/ClaimsInsurance/Providers/ProviderBulletins/
- ♦ Medical Aid Rules (WAC): http://www.LNI.wa.gov/ClaimsInsurance/Rules/.
- ❖ Fee Schedule: http://www.LNI.wa.gov/ClaimsInsurance/ProviderPay/FeeSchedules/